fare
Foundation for Alcohol Research & Education

30 November 2021

Mr Karl Holden
Committee Secretary
Community Support and Services Committee
Parliament House
George Street Brisbane Qld 4000
CSSC@parliament.qld.gov.au

Re. Criminal Law (Raising the Age of Responsibility) Amendment Bill 2021

Dear Mr Holden,

Thank you for the opportunity to provide a written submission to the Committee's Inquiry into the above Bill.

The Foundation for Alcohol Research and Education (FARE) is the leading not-for-profit organisation working towards an Australia free from alcohol harms. We approach this through developing evidence-informed policy, enabling people-powered advocacy and delivering health promotion programs. FARE has been working with communities across the country to improve the health and wellbeing of Australians for 20 years.

Alcohol harm in Queensland is significant. More than 1,000 people in Queensland die each year of alcohol-attributable disease and injury, and more than 30,000 Queensland hospitalisations are attributable to alcohol.[1] Cancers were responsible for the largest proportion of alcohol-attributable deaths, and neuropsychiatric conditions accounted for largest proportion of all alcohol-attributable hospitalisations.

Recently, the Queensland State Development and Regional Industries Committee asserted, that the Queensland Human Rights Act (HRA) requires public policy to address alcohol harm:

> *"Alcohol remains a significant cause of family and domestic violence in Australia: the use of alcohol and other drugs accompanies around half of all family and domestic violence incidents. Legislative measures which increase accessibility to alcohol, and especially alcohol usage in private homes, may therefore limit the rights of children and families and the right to security and liberty of the person. HRA s 26 emphasises the importance of the family, imposes an obligation on the State to protect the interests of children. Easy access to alcohol threatens not only children and families of alcohol consumers, but also the mental and physical health and security of consumers themselves."*[2]

FARE supports raising the Minimum Age of Criminal Responsibility (MACR) to at least 14 years old. FARE's particular interest in the MACR is due to the high prevalence of people detained in the criminal justice system, (including children), with Fetal Alcohol Spectrum Disorder (FASD).

FASD is a diagnostic term describing a range of neurodevelopmental impairments that impact on the brain and body of individuals prenatally exposed to alcohol.[3] FASD is a lifelong disability. Research at the Banksia Hill Youth Detention Centre in Western Australia identified that more than a third of the young people screened in detention were diagnosed with FASD.[4]

Aboriginal and Torres Strait Islander children are significantly overrepresented in Queensland's youth justice system. Queensland has the greatest proportion of First Nations children aged 10-14 held in detention of any Australian State or territory, with on average 84% of children aged 10-13 in a Queensland detention centre on any given day in 2019-20 identifying as Aboriginal or Torres Strait Islander.[5] First Nations children account for around 60% of all children aged 10 and 11 in contact with the Queensland Police Service, and their overrepresentation increases with each contact with the justice system.[6]

This submission covers the following areas:

- FASD and the alternative model;
- Victims' rights and supports;
- Threshold issues and transitional provisions and
- Electronic monitoring.

Each of these are explored in more detail below.

Evidence Briefs on MACR, FASD and Electronic Monitoring

The three evidence briefs attached along with this letter form part of this submission; they address:

- Raising the Minimum Age of Criminal Responsibility (MACR) (Attachment 1)
- Fetal Alcohol Spectrum Disorder (FASD), criminal justice and government responses (Attachment 2)
- Electronic Monitoring (including for Alcohol-Related Offences) (Attachment 3)

Summary of Recommendations

FARE recommends:

Recommendation 1: Raise the MACR to at least 14. All Australian State and Territory governments should raise the Minimum Age of Criminal Responsibility in their jurisdictions to at least 14 years old.

Recommendation 2: Educate relevant professionals about children with disabilities and cognitive impairment. This is essential for a better understanding by police, lawyers and the judiciary of how FASD and other impairments impacts on decision-making.

Recommendation 3: Include FASD in alternate pathway model design. Develop and fund appropriate alternative pathways for children suspected of having FASD or other neurological disorders that include adequate screening, diagnosis and ongoing support.

Recommendation 4: Develop FASD professional capacity. Invest in professional workforce development to establish adequate capacity in Queensland for FASD screening, diagnosis and support. Allocate resources to educating professionals in recognising FASD.

Recommendation 5: Include restorative justice processes in the new model. Consider voluntary restorative justice processes or elements, where appropriate, in designing the new model.

Recommendation 6: Use trauma-informed care. Implement an approach to care that is trauma-informed when engaging with children who are also victims of crime and survivors of trauma.

Recommendation 7: End Doli incapax for 10 to 14-year-olds. Replace *Doli incapax* by raising the MACR to at least 14 years old, but retain *Doli incapax* for people older than the MACR.

Recommendation 8: No exceptions. The MACR must be raised to at least 14 years old, with no exceptions and no exemptions.

Recommendation 9: Avoid net-widening. Ensure that any broader cohort accessing the new supports and services are not criminalised by any compliance consequences.

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Recommendation 10: Share essential only information about children. Limit the sharing of information related to children 10 to 14 years old, to relating to their release, or for child protection, case management, and investigation of suspected adult exploitation of children.

Recommendation 11. Discontinue the use of Electronic Monitoring (EM) with children. Re-assess the purpose, lived experience impact, human rights implications, costs and effectiveness of any trials and planned implementations of Electronic Monitoring (EM) programs.

Raising the Minimum Age of Criminal Responsibility (MACR)

This reform is based on neuro-developmental research and human rights obligations:

1. **Medical and social research on child development.** Research evidence on developmental psychology and brain development shows that children are not sufficiently able to reflect before acting or to comprehend the consequences of a criminal action.[7]
2. **International human rights obligations.** Australia has human rights obligations under the United Nations Convention on the Rights of the Child. These obligations state that the MACR should be at least 14 years old. [8]

In addition, the criminalisation of children is expensive and does not work.

- **Criminalising children is expensive**. It costs more than $1,600 for Queensland to keep one young person in detention each day.[9]
- **Criminalising children does not work.** Neurobiological research on early childhood trauma shows that criminalising children under 14 years old leads to a lifetime of harmful consequences, including sustained contact with the justice system.[10]

See the FARE evidence brief on Raising the Minimum Age of Criminal Responsibility (MACR) as Attachment 1.

Recommendation 1: Raise the MACR to at least 14. All Australian State and Territory governments should raise the Minimum Age of Criminal Responsibility in their jurisdictions to at least 14 years old.

Fetal Alcohol Spectrum Disorder (FASD) and the alternative model

FARE has a particular interest in MACR being raised due to the high prevalence of people detained in the criminal justice system, (including children), with Fetal Alcohol Spectrum Disorder (FASD).

Alcohol consumption in pregnancy increases the risk of children being born with FASD.[11] Alcohol passes across the placenta during pregnancy and the fetus has minimal ability to metabolise it due to its size and development. There is no safe time, no safe amount, and no safe type of alcohol that can be consumed during pregnancy. Other risks of alcohol consumption in pregnancy include miscarriage, stillbirth, low birth weight and pre-term birth.[12,13,14]

FASD is a diagnostic term describing a range of neurodevelopmental impairments[15]. It describes impacts on the brain and body of individuals prenatally exposed to alcohol. FASD is a lifelong disability. People with FASD experience challenges in their daily living and need support with motor skills, physical health, learning, memory, attention, communication, emotional regulation, and social skills to reach their full potential. Each person with FASD is unique and has areas of both strengths and challenges.[16]

Children with FASD can have cognitive, behavioural, health and learning difficulties, including problems with memory, attention, cause and effect reasoning, impulsivity, receptive language and adaptive functioning difficulties.[17] Despite the lack of intent, this can place them at increased risk of early contact with the criminal justice system.[18]

Recent research at the Banksia Hill Youth Detention Centre in Western Australia identified that more than a third of the young people screened in detention were diagnosed with FASD. Researchers

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suggested this may be an under-estimate due to, for example, the lack of confirmation of prenatal alcohol exposure, suspecting that almost half of these young people may have FASD.[19]

Given the higher prevalence of FASD currently present within youth justice settings, appropriate screening, diagnosis and ongoing support is critical to improving the lives of these children and to establishing an alternate pathway when the MACR is raised.

Submissions to the Senate Inquiry on FASD support a multi-disciplinary and community-based approach responding to the needs, (including cultural needs), of people with FASD who come into contact with the justice system. [20] International research and best practice indicate that this will address the inadequate accommodation of FASD-associated impairments within the criminal justice system and help maximise the therapeutic outcomes for people with FASD.

Additional funding and resourcing are needed for screening, diagnosis, assessment and support services. FASD diagnosis is complex, time-consuming and expensive and so it becomes difficult to access and many people miss out on the treatment and support that a diagnosis facilitates.

There is an urgent and critical need to educate health practitioners as many are not aware of the signs of FASD.[21] This can lead to children being misdiagnosed with Attention Deficit Hyperactivity Disorder (ADHD) or other disorders.[22] Children with FASD are likely to come in contact with General Practitioners, paediatricians, educators and social service providers. Each of these professions should be trained in recognising FASD to ensure that where suspected these children can be referred to appropriate diagnostic services and relevant support are identified as early as possible.

Another pathway for identifying and responding to children with FASD is through the school system. As the FASD Senate Inquiry recommended, Governments should ensure all schools can deploy and resource FASD-specific strategies and assistance to support educators and to support students with FASD and suspected FASD, irrespective of IQ level.[23]

Receiving a diagnosis is critical to children being supported appropriately and managing their disability to get the most from their lives. Referral for a FASD diagnostic assessment should occur when any of the following are identified:

- Prenatal alcohol exposure is at high risk levels
- Neurodevelopmental impairment and/or distinctive facial features and confirmed or suspected prenatal alcohol exposure
- The individual, their parent or caregiver is concerned that there was prenatal alcohol exposure and/or may be a FASD diagnosis

To ensure that this can occur, it is important that there are enough trained health professionals with the expertise required to undertake a FASD diagnosis in Queensland.

FASD is a frequently misunderstood and misdiagnosed disability. Given that approximately half the children who currently come into contact with the justice system have FASD, it is especially crucial that police, lawyers and the judiciary improve their understanding of how FASD impacts decision-making. Justice and legal professionals need multidisciplinary, trauma-informed, culturally-appropriate training about children with disabilities and cognitive impairment (including FASD) and the medical, social and legal implications[24]. This can help them identify and support young people suspected of having FASD or other neurological disorders.

See the FARE evidence brief on FASD, criminal justice and government responses as Attachment 2.

Recommendation 2: Educate relevant professionals about children with disabilities and cognitive impairment. This is essential for a better understanding by police, lawyers and the judiciary of how FASD and other impairments impacts on decision-making.

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Recommendation 3: Include FASD in alternate pathway model design. Develop and fund appropriate alternative pathways for children suspected of having FASD or other neurological disorders that include adequate screening, diagnosis and ongoing support.

Recommendation 4: Develop FASD professional capacity. Invest in professional workforce development to establish adequate capacity in Queensland for FASD screening, diagnosis and support. Allocate resources to educating professionals in recognising FASD.

Victims' rights and supports

Children who come into contact with the justice system are almost invariably themselves victims of significant abuse and traumatic experiences.[25] In many cases, this abuse has occurred while children are in state care. It is important to acknowledge the broader systems failures which have often occurred in these children's lives, and to avoid binary understandings of who is and is not a 'victim'.[26] This means that by better responding to children with these behaviours (in providing supports and services, instead of engaging with the justice system), the Queensland Government will also be better addressing the rights of these victims of crime.

For community members who have been harmed by the actions of children aged under 14, there are many ways in which the Queensland Government can recognise and redress that harm, outside of criminalising children. For example, there are victims of crime compensation mechanisms through which community members can access both financial compensation and other supports, without charges being laid nor convictions being sought. Other alternative approaches include no-fault schemes which are focused on meeting the needs of all people who have experienced harm.

The rights of victims can also be considered through restorative justice practices which are well established throughout the justice systems in Australia. The appropriateness of restorative justice would be dependent upon the cognitive capacity of the individual. Restorative justice programs that involve victims in justice processes have been found to increase victim and community satisfaction with the criminal justice system[27]. They are also found to be a cost-effective way to reduce imprisonment and reoffending.

Some elements of restorative justice programs may be able to be incorporated into the design of new supports and services. This could include mediated restitution processes where appropriate.[28] Currently, participation in restorative justice conferences in Queensland occurs on a voluntary basis.[29] As stated above, any mandatory compliance consequences risks both net-widening and undermining the principles that raising the MACR is based on, including the need to act in the best interests of the child.

Recommendation 5: Include restorative justice processes in the new model. Consider voluntary restorative justice processes or elements, where appropriate, in designing the new model.

Recommendation 6: Use trauma-informed care. Implement an approach to care that is trauma-informed when engaging with children who are also victims of crime and survivors of trauma.

Threshold issues and transitional provisions

There should not be any exemptions or exceptions to the new MACR. The evidence regarding brain development, and neurological disorders such as FASD, is the same regardless of the severity of behaviours. Effective supports and services implemented as alternatives to the justice system will address the causes and consequences of behaviours that would have brought children into contact with the justice system.

Community safety remains important in raising the MACR, but must be maintained without criminalising children. To improve community safety, children with serious problematic and harmful behaviour, should be referred for clinical assessment to assess their needs and identify causal factors such as

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trauma and potential neurological disorders, (including FASD). Assessment can help identify causal factors, triggers and appropriate behavioural strategies and approaches.

FARE welcomes the alternative model in the Bill to protect community safety that is decoupled from the criminal justice system. This includes prevention, early intervention and referral of children with problematic behaviour into alternative pathways to address their needs with evidence-based, restorative and therapeutic interventions. (See further detailed recommendations regarding the alternative model in the next section below.)

The current *Doli incapax* (deemed incapable of forming an intent to commit a crime), legal presumption is not an adequate alternative to raising MACR. *Doli incapax* does not take into account the scientific evidence on child and adolescent brain development. *Doli incapax*, which requires it to be proven that a child under 14 understands their criminal intent, is complex and legally opaque.

Raising the age of criminal responsibility to 14 years old is therefore a fairer, more consistent and more effective approach than the application of *Doli incapax*. However, the legal system also needs to recognise that children who are above 14 years of age also may not have the neurological capacity to form criminal intent. Thus, it must be understood that 14 is the absolute minimum age at which a child may be held criminally responsible – and for many children, especially children with FASD, they will not have reached a stage in their development where criminal intent can be formed. This is why many countries have raised the minimum age above 14 – including Sweden where it is 15, Portugal where it is 16 and Luxembourg where it is 18.

Early interaction with the criminal justice system does significant harm to children, especially if children are imprisoned. For children with disabilities, particularly disabilities like FASD, this harm is profound. When these children are criminalised or imprisoned early in their lives, they are significantly more likely to experience long-term mental illness, death by suicide, homelessness, repeated imprisonment and other adverse effects throughout the rest of their lives. For children with disabilities, who lose access to universal healthcare systems such as Medicare and the National Disability Insurance Scheme if they are imprisoned, their interaction with the criminal justice system can be deeply disruptive to their ability to receive the supports that they need.[30]

Often this disruption takes many years to be remedied, even after release from prison. In this sense, the criminal justice system can be an intervention which removes children and young people with FASD and other disabilities from access to any of the supports which enable improvements in future behaviour and wellbeing.

In the case of young adults with FASD or other neurodevelopmental disabilities, the Queensland Government should also consider dual track sentencing option. This allows adult courts to sentence young offenders (up to 21 years of age) to serve custodial sentences in youth detention instead of in adult prison. This is suitable for young people who are particularly impressionable, immature or likely to be subjected to undesirable influences in an adult prison. This system is in place in Victoria.[31]

Any mandatory elements in the new system, (such as intensive supervision for serious problematic and harmful behaviour), need to be carefully considered to avoid net-widening. This is especially in regards to any consequences of breaching mandatory compliance. The ACT MACR Discussion Paper suggests that there are likely to be more children and young people who can benefit from the additional support, but who would not have been subject to justice supervision orders.[32] Access to these supports and services for this broader cohort is welcomed, but they should be able to access them without risking any punitive compliance consequences.

FARE welcomes the Bill's transitional provisions that include extinguishing historical convictions and criminal records, destroying all related evidence and the restricted sharing of relevant information.

All historical convictions of children who were 10 to 14 years old at the time of the offence must be automatically extinguished on commencement of the Bill. Any evidence of behaviour from before

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children were 14 years old must not be used in future prosecutions. Police and courts must not be able to use / rely on behaviour that occurred before a child was 14 years old in future prosecutions.

In addition to facilitating their release from watch-houses and detention, police may also need to collect information about the child's harmful behaviour for child protection services, and the investigation of exploitation by adults. There may also need to be information-sharing provision for the multi-disciplinary panel assessing the needs of the child.

Recommendation 7: End Doli incapax for 10 to 14-year-olds. Replace *Doli incapax* by raising the MACR to at least 14 years old, but retain *Doli incapax* for people older than the MACR.

Recommendation 8: No exceptions. The MACR must be raised to at least 14 years old, with no exceptions and no exemptions.

Recommendation 9: Avoid net-widening. Ensure that any broader cohort accessing the new supports and services are not criminalised by any punitive compliance consequences.

Recommendation 10: Share essential only information about children. Limit the sharing of information related to children 10 to 14 years old, to relating to their release, or for child protection, case management, and investigation of suspected adult exploitation of children.

Electronic Monitoring (including ankle bracelets for children)

The Queensland and Northern Territory Governments both recently passed Youth Justice laws[33,34] that ignored expert evidence and increased the use of ankle bracelet Electronic Monitoring (EM) on children as young as ten years old.

Current evidence suggests that Electronic Monitoring (EM) in the criminal justice system is stigmatising, breaches human rights, is expensive and ineffective. The technology is unreliable, it does not reduce re-offending, does not reduce prison populations, it increases incarceration and does not treat problematic alcohol use. Electronic monitoring contributes to the criminalisation of children, First Nations peoples, people on low incomes and people with problematic alcohol and other drug use.

The Queensland Human Rights Commission states that EM breaches the human rights of privacy (lack of controls in how information gathered is being used by governments) and freedom of movement.[35] For human rights breaches to be acceptable and tolerated, the specific activity must have both a legitimate purpose and a rational connection to that purpose. Community safety through reducing crime or alcohol harm is a legitimate purpose. However, as the attached evidence brief demonstrates, EM does not have a rational connection to this purpose. The Queensland Human Rights Commission, and other EM evaluations, warn that this impacts social interactions, leads to stigmatisation, serious mental health consequences and the possibility of vigilantism.[36, 37,38]

See the FARE evidence brief on Electronic Monitoring as Attachment 3.

Recommendation 11. Discontinue the use of Electronic Monitoring (EM) with children. Re-assess the purpose, lived experience impact, human rights implications, costs and effectiveness of any trials and planned implementations of Electronic Monitoring (EM) programs.

Thank you for the opportunity to provide a submission to this Inquiry.

Yours sincerely,

CATERINA GIORGI
CHIEF EXECUTIVE OFFICER

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Foundation for Alcohol Research & Education

Raising the Minimum Age of Criminal Responsibility (MACR): An evidence brief

The purpose of this brief is to outline evidence about raising the Minimum Age of Criminal Responsibility (MACR), including the human rights obligations, medical and child development evidence. It explores the implications for young people with Fetal Alcohol Spectrum Disorder (FASD) and victims' rights and supports, and covers design elements of an alternative model to the current youth justice.

Key points

- Raising the Minimum Age of Criminal Responsibility reflects human rights obligations, medical and child development evidence.
- There is a high prevalence of young people with FASD in the criminal justice system.
- Aboriginal and Torres Strait Islander children are disproportionately impacted by these laws, being significantly over-represented in youth justice systems.
- Effective supports and services implemented as alternatives obviate the need for exemptions to raising the MACR.
- An alternative model to the youth justice system needs to include adequately resourced screening, assessment and support for people with FASD.
- Victims' rights can be supported in raising MACR, including through restorative justice processes.

1. Minimum Age of Criminal Responsibility

The Minimum Age of Criminal Responsibility (MACR) is the age below which a child is deemed incapable of having committed a criminal offence in a specific jurisdiction. The current MACR in almost all Australian State and territory jurisdictions is 10 years old. The Australian Capital territory (ACT) Government is the first Australian jurisdiction to commit to raising the Minimum Age of Criminal Responsibility (MACR) from 10 to 14 years old.

Raising the MACR is based on the following research and human rights obligations:

- **Medical and social research on child development.** Research evidence on developmental psychology and brain development shows that children are not sufficiently able to reflect before acting or to comprehend the consequences of a criminal action.[1]
- **Significantly improved life outcomes.** Neurobiological research on early childhood trauma shows that criminalising children under 14 years old leads to a lifetime of harmful consequences, including sustained contact with the justice system.[2]
- **International human rights obligations.** Australia has human rights obligations under the United Nations Convention on the Rights of the Child. These obligations state that the MACR should be at least 14 years old. [3]

2. Fetal Alcohol Spectrum Disorder (FASD)

Fetal Alcohol Spectrum Disorder (FASD) is a diagnostic term describing a range of neurodevelopmental impairments[4]. It describes impacts on the brain and body of individuals prenatally exposed to alcohol. FASD is a lifelong disability. People with FASD experience challenges in their daily living and need

support with motor skills, physical health, learning, memory, attention, communication, emotional regulation, and social skills to reach their full potential.

Raising MACR is important due to the high prevalence of children detained in the criminal justice system, with FASD. Children with FASD can have cognitive, behavioural, health and learning difficulties, including problems with memory, attention, cause and effect reasoning, impulsivity, receptive language and adaptive functioning difficulties.[5] Despite the lack of intent, this can place them at increased risk of early contact with the criminal justice system.[6]

Recent research at the Banksia Hill Youth Detention Centre in Western Australia identified that more than a third of the young people screened in detention were diagnosed with FASD. Researchers suggested this may be an under-estimate due to, for example, the lack of confirmation of prenatal alcohol exposure, suspecting that almost half of these young people may have FASD.[7]

3. Aboriginal and Torres Strait Islander children over-represented in youth justice systems

Aboriginal and Torres Strait Islander children are disproportionately impacted by these laws, being significantly over-represented in detention, accounting for almost two thirds (65 per cent) of younger children in prisons. The supervision rate for Aboriginal and Torres Strait Islander young people aged 10–17 was 16 times the non-Indigenous supervision rate in 2019–20. Aboriginal and Torres Strait Islander young people (75%) were more likely than non-Indigenous young people (63%) to have been under supervision in a previous year. Nearly 2 in 5 (38%) Aboriginal and Torres Strait Islander young people under supervision in 2019–20 were first supervised when aged 10–13, compared with about 1 in 7 (14%) non-Indigenous young people.[8]

As the Uluru Statement from the Heart says:

> *Proportionally, we are the most incarcerated people on the planet. We are not an innately criminal people. Our children are aliened from their families at unprecedented rates. This cannot be because we have no love for them. And our youth languish in detention in obscene numbers. They should be our hope for the future.*[9]

4. Potential exemptions to raising the MACR

Effective supports and services implemented as alternatives to the justice system can address the causes and consequences of behaviours that would have brought children into contact with the justice system. Community safety remains important in raising the MACR, but must be maintained without criminalising children. To improve community safety, children with behaviour that would have brought them into contact with the justice system, should be supported. Where appropriate they can be referred for clinical assessment to identify causal factors such as trauma and potential neurological disorders, (including FASD). Assessment can help identify causal factors, triggers and appropriate behavioural strategies and approaches.

Early interaction with the criminal justice system does significant harm to children, especially if children are imprisoned. For children with disabilities, particularly disabilities like FASD, this harm is profound. When these children are criminalised or imprisoned early in their lives, they are significantly more likely to experience long-term mental illness, death by suicide, homelessness, repeated imprisonment and other adverse effects throughout the rest of their lives.

For children with disabilities, who lose access to universal healthcare systems such as Medicare and the National Disability Insurance Scheme (NDIS) if they are imprisoned, their interaction with the criminal justice system can be deeply disruptive to their ability to receive the supports that they need.[10] Often this disruption takes many years to be remedied, even after release from prison. In this sense, the criminal justice system can be an intervention which removes children and young people with FASD and

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other disabilities from access to any of the supports which enable improvements in future behaviour and wellbeing.

5. An alternative model to the youth justice system

Given the higher prevalence of FASD currently present within youth justice settings, appropriate screening, diagnosis and ongoing support is critical to improving the lives of these children and to establishing an alternate pathway when the MACR is raised.

Submissions to the Senate Inquiry into Effective approaches to prevention, diagnosis and support for Fetal Alcohol Spectrum Disorder (Senate FASD Inquiry)[11] support a multi-disciplinary and community-based approach responding to the needs, (including cultural needs), of people with FASD who come into contact with the justice system.

Additional funding and resourcing are needed for screening, diagnosis, assessment and support services. Diagnosis is complex, time-consuming and expensive and so it becomes difficult to access and many people miss out on the treatment and support that a diagnosis facilitates.

There must be greater recognition and education of police, lawyers and judiciary regarding children with disabilities and cognitive impairment (including FASD) which can mean they do not have the cognitive capacity to form criminal intent and should not be dealt with by the criminal justice system at all. FASD is a frequently misunderstood and misdiagnosed disability. Given the higher prevalence of FASD among children who come into contact with the justice system, it is especially crucial that police, lawyers and the judiciary improve their understanding of how FASD impacts decision-making.

Another pathway for identifying and responding to children suspected of having FASD is in the school system. As the Senate FASD Inquiry recommended, Governments should ensure all schools can deploy and resource FASD-specific strategies and assistance to support educators and students with FASD and suspected FASD, irrespective of IQ level.[12]

Receiving a diagnosis is critical to children being supported appropriately and managing their disability to reach their full potential. To ensure that this can occur, it is important that there are enough health professionals with the expertise required to undertake a FASD diagnosis in each State and Territory. Justice and legal professionals also need multidisciplinary, trauma-informed, culturally-appropriate training about FASD and its medical, social and legal implications[13]. This can help them identify and manage young people suspected of having FASD or other neurological disorders.

6. Victims' rights and supports

Children who come into contact with the justice system are almost invariably themselves victims of significant abuse and traumatic experiences.[14] In many cases, this abuse has occurred while children are in state care. It is important to acknowledge the broader systems failures which have often occurred in these children's lives, and to avoid binary understandings of who is and is not a 'victim'.[15] This means that by better responding to children with these behaviours (in providing supports and services, instead of engaging with the justice system), State and Territory Governments will also be better addressing the rights of these victims of crime.

For community members who have been harmed by the actions of children aged under 14, there are many ways in which the State and Territory Governments can recognise and redress that harm, outside of criminalising children. For example, there are victims of crime compensation mechanisms through which community members can access both financial compensation and other supports, without charges being laid nor convictions being sought. Other alternative approaches include no-fault schemes which are focused on meeting the needs of all people who have experienced harm.

The rights of victims can also be considered through restorative justice practices which are well established in the justice systems of various States and Territories. The appropriateness of restorative

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justice would be dependent upon the cognitive capacity of the child. Restorative justice programs that involve victims in justice processes have been found to increase victim and community satisfaction with the criminal justice system[16]. They are also found to be a cost-effective way to reduce imprisonment and reoffending. Some elements of restorative justice programs may be able to be incorporated into the design of new supports and services

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Fetal Alcohol Spectrum Disorder (FASD), criminal justice and government responses: An evidence brief

The purpose of this brief is to outline evidence about Fetal Alcohol Spectrum Disorder (FASD), its prevalence in the criminal justice system, problems with screening, assessment, support and National Disability Insurance Scheme (NDIS) eligibility. It also focuses on actions that Australian Governments can take to address these issues.

Key points

- There is a high prevalence of FASD in the Criminal Justice System, with no routine screening.
- The Senate inquiry into *Effective approaches to prevention, diagnosis and support for FASD* (Senate FASD Inquiry) Inquiry made recommendations for State and Territory Governments to improve awareness, prevention and support for people with FASD, including screening young people in child protection and youth justice systems.
- FASD diagnosis is complex and expensive and there are limitations on screening and assessment. This leads to inadequate support and services for people with FASD.
- NDIS has gaps in access and eligibility for people with FASD.
- The Australian Government has funded a National Program on alcohol, pregnancy and breastfeeding.

1. Fetal Alcohol Spectrum Disorder (FASD)

Alcohol consumption in pregnancy increases the risk of children being born with FASD.[1] Alcohol passes across the placenta during pregnancy and the fetus has minimal ability to metabolise it due to its size and development. This is why the National Health and Medical Research Council recommends that 'women who are pregnant or planning a pregnancy should not drink alcohol'[2]. Other risks of alcohol consumption in pregnancy include miscarriage, stillbirth, low birth weight and pre-term birth.[3,4,5]

FASD is a diagnostic term describing a range of neurodevelopmental impairments[6]. It describes impacts on the brain and body of individuals prenatally exposed to alcohol. FASD is a lifelong disability. People with FASD experience challenges in their daily living and need support with motor skills, physical health, learning, memory, attention, communication, emotional regulation, and social skills to reach their full potential. Each person with FASD is unique and has areas of both strengths and challenges.[7]

FASD is the leading preventable developmental disability in Australia. Due to inadequate FASD screening and diagnosis, the prevalence of FASD is not known. However, estimates suggest that FASD affects between two to nine per cent of babies born each year. [8] Aboriginal and Torres Strait Islander communities are disproportionately affected by FASD, with a rate of up to 12 per cent of births in some remote communities.[9]

Without diagnosis and appropriate intervention, people with FASD have a higher likelihood of secondary issues such as requiring greater education, health and mental health support, problems with parenting and employment, homelessness, and problematic alcohol and other drug use.[10] With the many co-morbid conditions people with FASD experience,[11] the medical and social costs are great. In Australia, the annual cost of FASD in 2018 was estimated at $1.18 billion.[12]

Australia has comparatively high rates of alcohol consumption during pregnancy.[13] There are a range of factors contributing to this such as wider socio-cultural factors and the social environment around

women who are pregnant, including their own attitudes and beliefs.[14] Research has also shown that levels of alcohol use prior to the pregnancy and experience of intimate partner violence increase the likelihood of women using alcohol during pregnancy.[1516]

Other factors include:

- lack of awareness of the National Alcohol Guidelines and lack of awareness of risk,
- just over half (51 percent) of all pregnancies are unplanned,[17]
- relatively high levels of alcohol use across the population,[18]
- inadequate support and services for people with problematic alcohol use, and
- limited use of screening and brief interventions in antenatal care.

The underlying causes of FASD, therefore, are complex and prevention initiatives require a range of efforts to inform and support women who are pregnant to stop or reduce their alcohol intake. The World Health Organization *Global Strategy to reduce the harmful use of alcohol* acknowledges that whole of population approaches to alcohol policy, targeting the price, promotion and physical availability of alcohol, are the most cost-effective policy approaches to reduce overall population use and alcohol harm, including FASD.[19]

2. FASD and the Criminal Justice System

There is a high prevalence of FASD in people detained in the criminal justice system. Research at the Banksia Hill Youth Detention Centre in Western Australia identified that more than a third of the young people screened in detention were diagnosed with FASD. Researchers suggested this may be an under-estimate due to, for example, the lack of confirmation of prenatal alcohol exposure, suspecting that almost half of these young people may have FASD.[20]

People in the criminal justice system are excluded from the National Disability Insurance Scheme (NDIS), Disability Support Pension (DSP), Pharmaceutical Benefits Scheme (PBS) and Medicare. The exclusion of people in prison who have a cognitive disability from essential health and social security supports represents a substantial barrier to people with cognitive and mental health impairments getting adequate support, care and protection for their disability-related complex support needs. Screening, diagnosis and support should be made available for people in the criminal justice system.[21]

3. The Senate FASD Inquiry

The Australian Senate held an inquiry into *Effective approaches to prevention, diagnosis and support for FASD* (Senate FASD Inquiry) from 2019 to 2021. The final report,[22] released in March 2021, made 32 recommendations, some of which relate to areas where states and territories could make improvements. The relevant recommendations for State and Territory Governments are:

- **"Recommendation 12.** The committee recommends that the Australian Government fund a National Prevention Strategy to be developed and delivered in collaboration with State and Territory Governments." (p. 64)
- **"Recommendation 23.** The committee recommends that the Australian Government work with State and Territory Governments to provide all educators with professional development training in the awareness, understanding and management of FASD." (p. 111)
- **"Recommendation 24.** The committee recommends that the Australian Government work with State and Territory Governments to ensure all schools can deploy and resource FASD-specific strategies and assistance to support educators and to support students with FASD and suspected FASD, irrespective of IQ level." (p. 111)
- **"Recommendation 27.** The committee recommends that the Australian Government, in partnership with State and Territory Governments, develop and trial protocols for screening

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children and young people within child protection and youth justice systems for FASD." (p. 112)

These recommendations demonstrate the need for action across the health, education and criminal justice sectors to better prevent FASD and ensure that people with FASD and their families are supported.

4. FASD screening, assessment and support.

FASD diagnosis is complex and expensive and can be difficult to access. This results in many people missing out on the support that a diagnosis facilitates. Receiving a diagnosis is essential for them to be supported appropriately and take steps to manage their disability to get the most from their lives. Additional resources are needed for screening, assessment, diagnosis and support.

Diagnosis requires a multidisciplinary team to do complex physical and neurodevelopmental assessments. Health professionals participating in a diagnostic assessment for a young person may include Paediatrician, Psychologist, Speech pathologist, Occupational therapist. For an adult, the health professionals involved in the diagnostic process are most likely to include Psychiatrist or physician, Neuro or clinical psychologist, and Mental health worker.

Screening provides an initial assessment that can facilitate referrals to supports and services. Screening pathways through General Practitioners, paediatricians, educators and social service providers should be promoted to ensure children who would benefit from a diagnosis and relevant support are identified as early as possible.

The Senate FASD Inquiry recommended that Governments should ensure all schools can deploy and resource FASD-specific strategies and assistance to support educators and students with FASD and suspected FASD, irrespective of IQ level.[23] There is also an urgent and critical need to educate health practitioners as many are not aware of the signs or dismiss FASD prior to proper assessments being undertaken. This can include being misdiagnosed with Attention Deficit Hyperactivity Disorder (ADHD) or other disorders.[24]

Screening, diagnosis and support should especially include all those in the criminal justice system, but for both children and adults throughout the system. Given the high rates of FASD within youth justice settings, appropriate screening, diagnosis and ongoing support is critical to improving the lives of these children and establishing an ongoing pathway out of the criminal justice system.

5. National Disability Insurance Scheme access and eligibility

The Senate FASD Inquiry [25] noted that carers, families and individuals impacted by FASD face multiple barriers with the complex task of assessment, diagnosis and supports. People with FASD are further negatively impacted by issues within the National Disability Insurance Scheme (NDIS), such as gaps in funding and support options and a lack of coordination between the health system and the NDIS.

NDIS funding is available for people with FASD, but the process for accessing these supports is complex and fraught with barriers in relation to the burden of proof for functional impairments.[26] Due to this difficultly many people with FASD do not gain NDIS support or gain inadequate NDIS supports.

Another challenge with FASD and the NDIS is, as stated above, that people with FASD detained in the criminal justice system, including children, are excluded from the NDIS (and from DSP, PBS and Medicare). The exclusion of people in prison who have a cognitive disability from the NDIS represents a substantial barrier to people with cognitive and mental health impairments getting adequate support, care and protection for their disability-related complex support needs.[27]

Government intervention in addressing these gaps is critical as screening and assessment may be the only pathway for some people towards gaining a FASD diagnosis and the needed supports.

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6. National Program on alcohol, pregnancy and breastfeeding.

In December the National Health and Medical Research Council (NHMRC) released updated guidelines on alcohol. The *Australian guidelines to reduce health risks from drinking alcohol*[28] include "*Guideline 3: To prevent harm from alcohol to their unborn child, women who are pregnant or planning a pregnancy should not drink alcohol*". However, there is low awareness of the Alcohol Guidelines:

- In a study of Australian women aged 18 to 45 years, the majority reported negative attitudes about alcohol in pregnancy, however one in three women did not know that alcohol use in pregnancy could cause adverse impacts[29].
- Research of Australian women who were pregnant, planning a pregnancy, or who had recently had a baby found that while women were aware that alcohol consumption during pregnancy was "probably unsafe," they didn't have information about the actual risks of alcohol consumption during pregnancy for the developing child[30],[31] and did not view 'moderate' alcohol consumption or having an 'occasional' drink as being at odds with messages regarding alcohol abstinence[32].

FARE has received funding from the Australian Government Department of Health to develop and deliver the National Program on alcohol, pregnancy and breastfeeding from July 2020 to September 2024. The National Program has four streams: targeting the general public, health professionals, women who are most at risk and Aboriginal and Torres Strait Islander peoples. FARE looks forward to engaging with all State and Territory Governments to support the implementation of the National Program.

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Foundation for Alcohol Research & Education

Electronic Monitoring (including for Alcohol-Related Offences): An evidence brief

The purpose of this brief is to provide an overview of the current policy and research evidence about electronic monitoring, (including for alcohol-related offences) and the broader implications of such a policy. It considers human rights, lived experience, cost, effectiveness and alternatives.

Key points

- Electronic monitoring (EM) is expensive and ineffective, (the technology is unreliable, and it does not reduce crime).
- EM does not reduce re-offending, does not reduce prison populations, it increases incarceration
- EM breaches human rights of privacy and freedom of movement, is stigmatising, coercive and ignores the increased impact on women.
- EM contributes to the criminalisation of First Nations peoples and people on low incomes.
- EM criminalises people with problematic alcohol use, instead of treating it.
- EM has limited usefulness in preventing Domestic and Family Violence (DFV).
- EM is not the only alternative to incarceration.

Australian State and Territory Governments are considering or already implementing electronic monitoring, including ankle bracelets with transdermal alcohol-testing for alcohol-related offences.

1. Overview

Current evidence suggests that Electronic Monitoring (EM) in the criminal justice system is stigmatising, breaches human rights, is expensive and ineffective. The technology is unreliable, it does not reduce re-offending, does not reduce prison populations, it increases incarceration and does not treat problematic alcohol use. Electronic monitoring also contributes to the criminalisation of First Nations peoples, people on low incomes and people with problematic alcohol use.

> *EM is widely advocated and implemented across Europe, North America and Australia. It is touted as a programme that can cut costs, reduce prison overcrowding and reduce recidivism. Despite the popularity of EM, primary studies and reviews of the effectiveness of EM have produced sobering findings. This is clearly observed in the systematic reviews [which] concluded that EM has been applied seemingly without adequate thought, producing little effect on recidivism rates and at times giving rise to unintended consequences.*[1]

EM is an important emerging issue with the Queensland and Northern Territory governments recently passing Youth Justice laws[2,3] that ignored expert evidence and increased the use of ankle bracelet EM on children as young as ten years old. Other jurisdictions are also looking for technological solutions that may appear to address the spiralling criminal justice costs. However, EM does not reduce incarceration[4] and instead increases and diverts Police resources into correctional surveillance.

Research appears to suggest a reduction in crime when EM is used in conjunction with other strategies, (for example, throughcare support, employment or training, regular AOD treatment). However, it is those other strategies that are attributed as the key factors in reducing reoffending.[5] Likewise, research appearing to identify cost-benefit savings falsely presume an overall reduction in prison population.[6]

2. First Nations

Electronic Monitoring criminalises First Nations peoples. Aboriginal and Torres Strait Islander peak bodies have expressed their opposition to the use of electronic monitoring devices, saying they breach human rights, fail to improve community safety, and have a high risk of causing further harm.[7] Academics have also indicated that EM widens the net of law enforcement that disproportionately targets Aboriginal and Torres Strait Islander peoples.[8]

Aboriginal and Torres Strait Islander peoples are overrepresented in Australia's criminal justice system. However, this growth in incarceration rates cannot be explained by changes in offending. The evidence does not suggest that offending rates amongst Aboriginal and Torres Strait Islander peoples have risen. [9]

The level of incarceration among Aboriginal and Torres Strait Islander peoples is likely caused by greater exposure to risk factors reflecting entrenched social and economic disadvantage caused by colonisation and dispossession. Such risk factors would include problematic alcohol use, along with unemployment, low levels of educational participation, mental health issues and disabilities including Fetal Alcohol Spectrum Disorder (FASD). However, given these do not reflect in increased levels of offending, this suggests that other factors, such as changes to criminal justice policies, (including EM), are driving the increased incarceration rates, and that these disproportionately affect Aboriginal and Torres Strait Islander peoples.[10]

In 2011, a 30-year-old Aboriginal man in South Australia, died after consuming lighter fluid, while subject to electronic monitoring with drug testing to identify alcohol or marijuana use that violated his bail restrictions. His partner gave evidence to the inquest into his death that he used lighter fluid while he was on bail as a substitute for alcohol and other drugs because of his bail conditions.[11]

3. Voices of lived experience

The following stories are of people with lived experience of EM using ankle bracelets. They describe, in their own words, what it is like living with EM ankle bracelets.

"Living with an Ankle Bracelet"

The quotes below are from 'M.M.' in a 'Marshall Project' article.[12] He has been on parole for more than three years on multiple charges stemming from an altercation when he was 22 and his subsequent re-arrest for driving while intoxicated.

> *"I cannot sleep. There is a device on my leg. It requires that I wake up an hour early so I can plug it into a charger and stand next to the outlet, like a cell phone charging up for the day. Not the day, actually, but 12 hours. After that, the device runs out of juice. Wherever I am, I have to find an outlet to plug myself into. The device is my ankle bracelet. I wear it afraid that someone at work will notice the bulge. When I go to school, I worry my friends will spot it and leave me. I push it up into my jeans, hoping they won't see. But the higher up I push it, the more it starts to hurt; most days, my feet go numb. I try wearing bell-bottoms.*
>
> *Throughout the day, the device becomes heavier and more painful, causing me to bleed. I push it down on my ankle to let my blood circulate — but then the pain becomes unbearable, and I can't plant my feet without crying out. The device is, both literally and metaphorically, my greatest source of pain. But every day I rise, stand by the socket, and charge my ankle to go to work."*

"'Digital shackles': the unexpected cruelty of ankle monitors"

These quotes are from a 'Guardian' article,[13] which details some experiences of people subject to EM.

> *"It's like a rope around my neck, I can't get my feet back on the ground."* (Willard)
>
> *"It's horrible. A living nightmare."* (William)

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> *"It's hard to imagine wearing it for 30 more years," she said. "It's depressing and upsetting to imagine having that much of my life monitored."* (Sarah)

"Ankle Monitors Aren't Humane. They're Another Kind of Jail"

These quotes are from a 'Wired' article[14] written by James and Emmet, who have lived under EM.

> *"To many, electronic monitoring is humane—one that allows people "on the bracelet" to live at home and move about more freely than they would behind bars. But those who have lived under this high-tech tether—including the two of us—see it differently. For many, electronic monitoring equals incarceration by another name. It is a shackle, rather than a bracelet. The rules for wearing a monitor are far more restrictive than most people realize. Most devices today have GPS tracking, recording every movement and potentially eroding rights in ways you can't imagine."*
>
> *"There is no real proof that these devices make communities safer. Instead, the monitors function as an additional punishment, extending a person's sentence when they're placed on a monitor as part of parole. Or, they severely curtail the freedoms of those who are given a device before they've even been convicted. The money spent on this under-regulated and misunderstood technology would be better used to provide jobs or housing."*

Poverty

Electronic Monitoring criminalises poverty. People on low incomes and people accessing income support, including people with problematic alcohol and other drug (AOD) use, often experience stigmatisation and discrimination.[15] Governments have been increasingly automating systems that people in poverty access, [16] often without adequate safeguards or justice, and with significant negative consequences, such as with robo-debt.[17]

The EM technology is expensive and, in some jurisdictions, people wearing the EM devices are charged a fee to help recover the costs. This places extra hardship on people on low incomes, and if they are not able to meet this requirement, may risk breaching their orders.[18]

Also, people released into the community with EM often have little access to paid employment so the family bear the cost of running the home prison[19]. This reinforces the 'double punishment' effect of imprisonment where a person is not only punished by have their liberty restricted, but also by receiving significant, and ongoing financial punishment beyond their term of incarceration.[20]

4. Human rights

Privacy and freedom of movement

Electronic Monitoring breaches human rights of privacy and freedom of movement. The Queensland Human Rights Commission states that EM breaches the human rights of privacy (lack of controls in how information gathered is being used by governments) and freedom of movement.[21] For breaches to be acceptable and tolerated, the specific activity must have both a legitimate purpose and a rational connection to that purpose. Community safety through reducing crime or alcohol harm is a legitimate purpose. However, as this evidence brief demonstrates, EM does not have a rational connection to this purpose.

Stigmatising

Electronic Monitoring is stigmatising. The ankle bracelets, including alcohol detection anklets, can be quite large and easily visible. The visibility of the device means wearers can be identified by members of the public. The Queensland Human Rights Commission, and other EM evaluations, warn that this impacts social interactions, leads to stigmatisation, serious mental health consequences and the possibility of vigilantism.[22, 23, 24, 25,26]

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Lack of consent

Electronic Monitoring is coercive. Genuine consent involves free, informed and voluntary permission. People subject to criminal justice orders clearly often have no option to decline giving consent. However, even when offered the choice of EM over prison there is severely restricted options available, including limited options to the people sharing the person's home.

In Victoria, for a person to be granted EM at home, the entire family (including children) must be interviewed, assessed and provide consent for EM, including 24-hour phone calls, right of entry and search of the entire residence, and discussions about the detainee's progress. There is no real choice when the only other option is for their family member to stay in prison.

This situation also ignores the nature of consent and coercion in regards to gender and power relationships. There are concerns about women fearing the consequences of not giving consent to their homes becoming prisons for their partners, compared to them being on parole. This places a burden on them to consent to their male partner being restricted to the area for months.[27]

Gender

Electronic Monitoring ignores the increased impact on women. As with many criminal justice programs, the focus of EM is largely on men as they comprise the overwhelming majority of offenders. The position of women who may offend is often assumed to be the same as males, ignored or marginalised. Yet there are structural biases which make it more difficult for women offenders, particularly single parents, to fulfil the eligibility requirements, particularly housing difficulties and poverty. As stated above, the impact on women sponsors within the home setting, is also as a concern. Home detention with EM creates risks for family violence.[28]

5. Cost

Electronic Monitoring is expensive. All AOD testing is expensive,[29] and EM even more so as ankle bracelets with transdermal alcohol-testing can cost up to $9,000 each.[30] Although some technologies are more expensive than others, EM is overall, a cheaper alternative to prison, (that is, if imprisonment numbers were declining). However, EM is more expensive than traditional parole or probation without EM. Research studies that appear to identify cost-benefit savings (compared with incarceration) falsely presume an overall reduction in prison population, which is not occurring.[31]

The cost of EM includes the individual's expense of recharging and internet access, (not always reliable in regional and remote areas). In some jurisdictions people are charged an amount to cover the cost of the monitoring.[32] The average cost of imprisonment for keeping people who offend in prisons is nine times more than the average cost of a community order.[33] However, community-based programs without EM are even cheaper again than EM-based community orders.

6. Effectiveness

Technological capability

Electronic Monitoring technology is unreliable. Providers of EM, including ankle bracelets with transdermal alcohol testing, have been continuously upgrading the technology. However, the technology continues to have limitations in regard to effectiveness and accuracy.[34, 35 36]

A study of the current technology published in 2021, indicates that wearable transdermal alcohol monitors are either unable to detect low-to-moderate drinking levels or they show a high failure rate.[37] Other technical problems arise due to the common limitations of correct set-up (including adequate information provided to the individual), reliable power supply, internet coverage and remote storage of data.[38]

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Crime

Electronic Monitoring does not reduce crime or reoffending. There is no statistically significant evidence that EM trackers have a positive effect on reducing crime or reoffending.[39,40] The only exception may be when used for sex offenders placed on EM post-trial.

Governments continue to treat problematic alcohol and other drug (AOD) use as a criminal justice issue, instead of a public health issue, (see section below on problematic alcohol use). As a result, use of alcohol and other drugs remains more prevalent among people in contact with the criminal justice system than the general population.[41] Yet prison AOD treatment programs, are rare, difficult to access, inadequate and ineffective.[42]

Prison population

Electronic Monitoring does not reduce prison populations. Evidence indicates that both prison populations and alternatives (such as community sanctions and EM) have both increased despite the reduction in crime rates. [43] EM also facilitates people's homes being made into prisons, meaning the capacity for incarceration is virtually unlimited,[44],[45] and reduces the imperative to address prison overcrowding or endless privatised expansions.[46]

Net-widening

Electronic Monitoring increases incarceration. Net-widening is where criminal justice policies or practices are changed in a way that results in a greater number of individuals being incarcerated, regardless of changes in offending rates. When used pre-trial as part of bail conditions, EM increases the likelihood of a custodial sentence. This occurs for breach of bail conditions for minor offences that would not have otherwise attracted a custodial sentence, and thus increases the severity of the sentence.[47]

This applies to other forms of AOD testing in the criminal justice system where probation officers have some discretion in their response to individuals testing positive for alcohol or other drugs. They are aware of the counter-productive nature of breaching people with problematic AOD use. Probation officers have observed that there is no point testing offenders with problematic AOD use who would not be able to stop regardless of the accountability or the punishments for continuing. This just sets them up to fail by providing a pathway for them to be breached and go back to prison, rather than a rehabilitative pathway.[48]

Problematic alcohol use

Electronic Monitoring criminalises problematic alcohol use instead of treating it. Australia relies heavily on the criminal justice system to respond to problematic alcohol and other drug use despite clear evidence that it is better dealt with as a health issue.[49] Using EM (including ankle bracelets with transdermal alcohol testing) further criminalises problematic alcohol use. EM can monitor an individual's alcohol use but it cannot assess the reasons why the person uses alcohol, as it does not address recommended therapeutic principles. The focus is on compliance, not treatment.[50]

EM (including ankle bracelets with transdermal alcohol testing) is not an indicated therapeutic treatment of problematic alcohol use, it is coercive not rehabilitative. Evidence-based behavioural therapies for problematic AOD use include Cognitive Behavioural Therapy, Contingency Management Interventions, Motivational Enhancement Therapy, Community Reinforcement Approach, and 12-Step Facilitation Therapy (such as Alcoholics Anonymous).[51]

The Australian National Drug Strategy (2017-2026)[52] is based on demand reduction, supply reduction and harm reduction. However, the dominant strategy for dealing with problematic drug use is based on a policy of criminalisation. Criminalisation has been in place for many decades, but it has proven ineffective at significantly reducing the use of illicit drugs and has not achieved sustained reductions in supply. Criminalisation has created significant costs and unintended harms.[53]

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The Australian National Alcohol Strategy (2019-2028)[54] likewise is based on harm minimisation. The Strategy is structured around four priorities: improving community safety and amenity; managing availability, price and promotion; supporting individuals to obtain help and systems to respond; and promoting healthier communities. None of these evidence-based, public health responses involves the criminal justice system.

Domestic and family violence

Electronic Monitoring has limited usefulness in preventing DFV. EM is limited in preventing domestic and family violence (DFV) because of the nature of offenders and of DFV itself. It is also limited due to the capability of the technology itself; and the criminalising risks.

DFV includes coercive controlling abuse that may be perpetrated through various means beyond EM surveillance. These can include: threats, intimidation and harassment conveyed via mail, email, mobile phone or text message or via a third party acting for the offender. The intractable determination of some offenders to 'punish' their ex-partner means that they will stop at nothing, including EM, to attack the victim. These offenders find ways to manipulate the technology and are an unacceptable risk to the safety and wellbeing of their ex-partners.[55]

Australia's National Research Organisation for Women's Safety (ANROWS) suggests that comprehensive best practice could incorporate EM, requiring the following five elements:

1. Comprehensive risk assessment and risk management
2. Evidence-based, reliable EM technology and responsive monitoring systems
3. Effective supervision of defendants/offenders and their participation in structured programs
4. Co-operation and information-sharing between technology providers and criminal justice and community agencies
5. Active inclusion in decision-making and information-sharing and safety planning with those who are at risk of further harm from the offender. [56]

However, ANROWS also warns that these principles are inter-connected and cannot be applied in isolation. The consistent, adequately resourced application of all five principles is essential to the effective application of EM in the limited context of DFV.

7. Review of U.S. and New Zealand Programs

Criminal justice programs using EM with alcohol detection ankle bracelets have been trialled and evaluated in various international jurisdictions. The following is evidence from evaluations of EM for alcohol-related offences in programs in the U.S. and in New Zealand.

South Dakota 24/7 Sobriety program

The 24/7 Sobriety Project began in 2005 and is a court-based management program originally designed for repeat Driving Under the Influence (DUI) offenders. The program originated in South Dakota and is now being implemented in many other U.S. states. It uses a variety of mechanisms to ensure abstinence from alcohol and other drugs, including SCRAM ankle bracelets with alcohol-detection.

Evaluations of the 24/7 Sobriety Program do not address the concerns above regarding lived experience, human rights, stigma, net-widening or effective treatment of problematic alcohol use. However, they do provide some statistical measure of the immediate impact on crime and recidivism within the limited context of the criminal justice system.

Number of car crashes. With respect to traffic crashes, the evidence was not conclusive. 24/7 did not reduce overall traffic crashes, but there is suggestive evidence that crashes among males age 18–40 fell as a result of the program.[57]

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Probability of a DUI re-arrest. Results from statistical models provide *suggestive* evidence that 24/7 participation reduced the probability of DUI re-arrest (perhaps on the order of 45% to 70%), but missing criminal history information for approximately half of the sample prevents making stronger conclusions about causality.[58] Individual-level probability of rearrest is moderately (13.7 per cent) lower for 24/7 participants than non-participants 12 months after their DUI arrest.[59]

Adult mortality. Randomised controlled trials and analyses of individual-level data, is needed to corroborate a finding of a drop in all-cause adult mortality, reassess the strength of the associations, and understand causal mechanisms.[60]

The New Zealand AODT program

The New Zealand Alcohol and Other Drug Treatment (AODT) Court, was established in Auckland and Waitākere in 2012. In 2019, it was announced that the pilot courts would be made permanent. AODT incorporates multiple strategies, (including intensive monitoring with Alcohol Detection Anklets), where sentencing is deferred while participants work through the program. The program takes one to two years to complete. Following is evidence from multiple evaluations of the AODT program.

Alcohol Detection Anklets (ADAs) were ineffective in reducing recidivism. This was particularly evident with respect to reoffending rates, which were not lower than would be expected under normal conditions. Available evidence is unfavourable to continued investment in the relatively expensive ADA option.[61]

The program had no effect on the majority of offenders. The largest group of offenders explained that testing had no effect on their substance use as they already decided to abstain from AOD.[62]

The program has no sustainable benefit. Over follow-up periods, the effectiveness of the AODT program in reducing reoffending and imprisonment declines markedly. The only significant difference for the reoffending rate and frequency of reoffending measures was within three years, and no significant differences in a four-year follow-up period.[63] Recidivism rates are found to be comparable with those who have not been subject to ADA.[64]

Officers observed net-widening effects of enforcing of breaches. Probation officers observed that there was no point in testing offenders who had problematic AOD use and who were not able to stop regardless of accountability or punishments. The testing was setting offenders up to fail by providing a pathway for them to be breached and go back to prison rather than a rehabilitative pathway.[65]

ADAs were stigmatising. Offenders with Alcohol Detection Anklets did not find them comfortable. The ADA device could be casually observed. Visibility of the device meant offenders could be identified as offenders by members of the public. That impacted social interactions and could result in the offender being exposed to questioning they would prefer to avoid about their offending and community sentence."[66]

ADAs were expensive. The ADA element of the pilot has required the larger share of funding.[67]

ADAs had technical problems. Staff thought many offenders had not received information about the ADA. They were concerned the offender may not have the required information around things like mouth wash, deodorants or creams that contain alcohol or how to look after the device.[68]

8. Alternatives

Electronic Monitoring is not the only alternative to incarceration. EM (including Ankle Bracelets with transdermal alcohol testing) is framed as a cheaper alternative to incarceration. However, the evidence suggests that EM is stigmatising, unreliable, breaches human rights, doesn't treat problematic alcohol use, nor does it reduce crime, costs or prison populations. Treating public health issues such as problematic AOD use, and disabilities such as FASD, as health issues, not criminalising them, reduces harm in the community and reduces prison populations, costs and recidivism.

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Even within the criminal justice system, there are many other sentencing alternatives to incarceration available, including other alternatives for prison sentences served in the community. These cheaper and more effective alternatives involve community work, rehabilitation programs, and intensive reporting to corrections officers. Yet, rates of community-based sentences have decreased whilst imprisonment rates have increased, due to poorly resourced programs and the media fuelled demands for 'harsher' sentences.[69]

An example of a successful community-based program is the Work and Development Orders (WDOs) system first successfully implemented in NSW,[70] and now also being run in Queensland.[71] These orders are an extension of previous community orders for people defaulting on state government fines. Activities that can be completed as part of a WDO are unpaid work; medical or mental health treatment by approved practitioners; educational, vocational or life skills courses; financial or other counselling and drug or alcohol treatment. Mentoring programs are included and culturally appropriate programs for Aboriginal or Torres Strait Islander peoples living in remote areas.[72]

Other community-based programs that have been assessed include residential drug and alcohol treatment for Indigenous offenders, which have been found to have significant financial savings when compared with incarceration.[73]

9. Conclusion

Evidence suggests that EM does not reduce crime, costs or prison populations. In addition, EM has been found to be unreliable, stigmatising, in breach of human rights, and unable to treat problematic alcohol use. There are effective, evidence-based, public health and community-based alternatives to Electronic Monitoring for responding to problematic alcohol use and alcohol-related offences.

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